think we need to encourage nurse trainers to similarly review their teaching.

I recently became aware that student nurses at a local college were being taught about ECT by being shown a BBC film made in 1983. The same college does not currently involve any medical staff in their teaching on ECT. The film included information, not revised, including indications for unilateral ECT, the position of the electrodes, describable seizure length and the incidence of memory disturbance. Much more disturbing than this, however, were scenes (historically interesting no doubt) of patients, and a series of animals, receiving ECT without anaesthetic.

We all have a responsibility to be teaching nurses the most up to date knowledge available. This is of paramount importance when dealing with the emotive subject of ECT about which there are so many unhelpful myths.

D. KINGHAM, *Mental Health Services, Barrow Hospital, Barrow Gurney, Bristol BS19 3SG*

## The development of a generic psychiatric in-patient facility

Sir: I feel that the experience that I have had over the past three years of developing combined psychiatric in-patient treatment for all patients over the age of 16 may be of interest to those working in the more isolated areas of the community.

The original 20-bedded ward, part of an acute general hospital re-build, was designed for psychiatric patients over the age of 65. With the advent of care in the community, the commitment for offering service close to the patient's own home, and the development of long-term nursing home beds, we felt we would pilot a scheme in which all psychiatric patients over the age of 16 could be admitted locally. Our only caveat was that aggressive, violent patients would be admitted directly to the intensive care beds in the central unit at Cheltenham.

The Cirencester population served is 38,000 of whom over 16% are elderly. It is a country area of several market towns, farming, service and light industry forming the principal occupations. We already had a thriving resource centre, with a committed day hospital and ECT facilities. With the total support of all staff a pilot scheme was instigated. The trust agreed to fund small structural alterations, enabling us to use our beds more flexibly, and with the loss of one bed. We designated 14 beds to the elderly and five for the adult patients.

Our review after a year showed we had treated 117 adults, of whom only four had had to be admitted to Cheltenham, and they had been transferred back after a short stay. A complete range of illness had been treated, the length of stay perhaps a little shorter than might have been expected, and we had offered some short-term asylum care. All other objective targets had been achieved, and the subjective reports from staff, patients and relatives had been very good. Patients mixed well, and all gained from the mixed therapeutic milieu. Of course, the cost of pharmacy and catering had risen, as expected, but care had been achieved with no increase of staff numbers.

The trust, encouraged by these results, agreed to the permanent change of use of the ward. Purchasers agreed to pay for the service, and the Mental Health Commission was satisfied at the last visit. We feel that a generic psychiatric ward in either a community or small general hospital unit may be the way forward for offering a quality psychiatric service to an isolated community.

A. M. WILSON, *Kinnaird, London Road, Poulton, Cirencester GL7 5JQ*

## Defeat Depression Campaign: attitudes to depression

Sir: We are grateful to Professor Priest for his response to our article (*Psychiatric Bulletin*, 1994, **8**, 573–574) (572–573), criticising the methodological basis of the College's Defeat Depression Campaign. As he points out, he does not answer the theoretical objections which we consider fundamental and serious, well established in the field of epidemiology, public health and medical anthropology. We are surprised that he agrees the experimental method is not appropriate, but then justifies the campaign on which it is based.

If the credibility of the MORI results are doubted by Priest himself, we have difficulty understanding his paragraph outlining plans to 'correct' one (just one) impression revealed in the MORI survey: that of antidepressants being addictive. As we noted in detail there is evidence in public health research that such 'impressions' are unstable, contextual and

determined by several interacting variables. If the MORI poll is to be repeated on the same population (to test the efficacy of the campaign), it would become evident that such 'impressions' are far from robust. We assume the campaign would then conclude that any shift in 'impression' was due to its health education programme.

Our intention was not pejorative as Priest suggests: the campaign *is* glossy, linking antidepressants with happiness, gala dances, and 'fun' runs, video packs, leaflets and press releases, not to mention the unfortunate similarity between its logo and that of a currently marketed antidepressant.

Professor Priest decries our critiques as 'syllogisms'. We are unable to detect any such Aristotelianism in our letter, but one could rephrase his response as:

(a) the campaign is based on a dubious experimental method
(b) the campaign is justified on other grounds.

Therefore: criticisms of the method are irrelevant.

ROLAND LITTLEWOOD and SUSHRUT JADHAV, *University College London Medical School, Riding House Street, London W1N 8AA*

Sir: I am sorry that Littlewood & Jadhav cannot see the wood for the trees. I am very pleased to say that their negative view is not shared by many others.

The scientific basis of the Defeat Depression Campaign was published in the *British Medical Journal* (Paykel & Priest, *British Medical Journal*, 1992, **305**, 1198–1202). Littlewood & Jadhav were confused about the need for our campaign. To most doctors the *fact* that people affected by depression suffer in silence without going to their GPs, that GPs fail to recognise a substantial proportion when they do attend, and that depressed patients do not get the best treatment when they are recognised is motivation enough.

The campaign is going well. The initiative to improve the recognition and treatment of depression in primary care is now at full steam. Over the last 12 months we have started our project to get the public more prepared to seek treatment for depression (whether by psychological or pharmacological means) and we have had a gratifying response from the media. The general reaction has been very sympathetic. Our educational materials have been funded from a variety of sources, including public donations, the results of appeals and grants from charities. A more detailed report will appear in the *Psychiatric Bulletin* within the next few months.

R. G. PRIEST, *Chairman, Defeat Depression Campaign Management Committee*

## Psychiatry in Argentina

Sir: Professor McClelland's article 'A visit to Argentina' (*Psychiatric Bulletin*, 1994, **18**, 569–571) describes with accuracy many problems psychiatry faces in that country. Most of his description is focused on Buenos Aires. Other provinces do not necessarily share identical problems, such as Mendoza, the fourth largest city of Argentina, where I began my training. The scheme I joined had a strong influence from the department of psychiatry at the local university which had firm roots in existentialist philosophies and a discouraging attitude towards pyschoanalysis. The recommendations made in the article were to a great extent met in that scheme in Mendoza, but not necessarily so in other parts of the country, as Argentina is a Federal Republic.

As pointed out, many Argentinian psychiatrists, particularly those occupying posts of power such as hospital directors, overidentified with various political regimes. This overidentification stood firm even when the political regimes changed from totalitarian to more democratic ones; most of those people continued in charge of those same posts, greatly impeding change.

Those who voiced the needs of psychiatric patients and denounced corrupted practice were labelled subversive or reactionary, and the lesser punishment was loss of their jobs. This also happened in other areas of the medical profession. It is unfortunate that echoes of some of my experience in Argentina are happening in this country; the *Daily Telegraph* (September 1994) published an article referring to a consultant physician who was facing dismissal because he made unfavourable comments on the reforms about the NHS.

I left Argentina almost ten years ago; I still exchange correspondence with friends who trained with me. Regrettably, their recent comments reflect a similar picture to the one I remember.



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